The World Bank and world health

Focus on South Asia—II: India and Pakistan

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This is the fifth in a series of six articles examining the World Bank's role in international health

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For a better understanding of the effectiveness of the World Bank's policies and of how they are perceived I visited bank projects in Bangladesh (see last week's article[1]), India, and Pakistan.

Summary points

- India is the World Bank's largest single borrower, with cumulative loans over $44bn
- India's diversity, "enormous" burden of disease, and chronic underfunding of health care have hindered progress
- Despite Pakistan's relatively high gross national product per capita, its health indicators compare poorly with those of its neighbours
- Social action programmes, promoted by the bank, have been controversial
- Although the bank has adopted differing approaches to the countries of South Asia, the substantial challenges posed by the region mean that progress will be slow

India: diversity and disease

India's vastness, diversity, and poverty are challenges that the World Bank has responded to with huge sums of money. With cumulative loans of more than $44bn, India is the bank's largest single borrower. Even in fiscal year 1998 (from June 1997 to June 1998), when an exchange of nuclear tests with neighbouring Pakistan resulted in the temporary freezing of bank loans to the region, lending reached a record $3bn. India is also the recipient of the largest sum of interest free credits from the International Development Association. By April 1998, India had received 167 loans and 223 development credits, with 84 ongoing projects amounting to $14.5bn. Power projects accounted for 24% of lending, and health, nutrition, and population programmes received 14%.[2 3]

"The nuclear sanctions won't have greatly affected India," argues Dr Anthony Measham, the bank's chief health adviser in the country. "Sanctions don't affect ongoing projects. The only ones that are affected are the new projects, and we are continuing all ongoing work. We're working in a harmonious way to overcome problems; we're an apolitical organisation." The other crucial factor is that foreign investment accounts for 1-1.5% of India's gross domestic product; it accounts for a much larger proportion of Pakistan's.

India's population has an "enormous" burden of disease, especially in communicable diseases like AIDS and leprosy, and in women of reproductive age. Malnutrition is another major challenge: figures indicate that half of children under 5 are undernourished, and around a third of newborns are of low birthweight. It also exemplifies the variability between states (table 1). While the Tamil Nadu Integrated Nutrition Programme has been described by the bank as "highly effective," Bihar, Rajasthan, and Utter Pradesh, in the Hindi speaking belt of northern India (figure), are struggling to improve their malnutrition rates. One factor holding back progress, the bank believes, is that although public sector spending on nutrition has increased, it remains markedly below what is needed.

The states of India

Moreover, the bank believes that India has historically made "an inadequate effort to address public health problems." Over the years, spending on health has amounted to around 1.5% of gross domestic product, with an even lower proportion being spent on public health. Even those few public health measures that have been funded have had limited efficacy because of poor execution. Fundamentally, the bank's view is that "the institutional base for health services is weak," non-governmental organisations are underutilised, and finally, but perhaps most significantly, the private sector is "gigantic," virtually completely unregulated, and offers "some of the best and the worst care seen anywhere."

Richard Skolnik, the bank's health, nutrition, and population sector leader for South Asia, explains the bank's approach: "In India, we started with specific disease control programmes because we thought they would have a definite and very quick impact on the health of very poor people, without prejudicing the outcome of the health system in a bad direction.

Simultaneously, we began moving the health system in the right direction."

Vital women

The bank proposes to reduce the burden of disease by continuing with specific programmes for reproductive health and child health, malnutrition, and for diseases like AIDS, cataract blindness, leprosy, malaria, and tuberculosis, while attempting to make the state healthcare system more effective and efficient and enhancing quality control and consumer protection. Progress hinges on government cooperation and "good donor partnerships."

An important aspect of the bank's strategy is women's issues. The bank strongly believes that women hold the key to improvements in health indicators, and it aims to focus on projects that help them: girls' education, reproductive and child health, and reduction in the fertility rate. For example, according to Indian government figures, female literacy in the southern state of Kerala is 87% and the infant mortality rate is 17 deaths per 1000 live births, while in the northern state of Rajasthan the female literacy rate is 21% and infant mortality is 90/1000 live births.[5 6] Women's education and emancipation is one of the reasons why southern Indian states are much better placed than the northern ones; in a sense, there is a north-south divide. Anthony Measham suggests that other factors too come into play to explain this dichotomy. In southern India, women play a more important economic role, and issues of caste are less prominent, he believes. Non-governmental organisations also have a vital role.

The urban slums project in Hyderabad, Andhra Pradesh, utilises non-governmental organisations to educate girls and women about their general health and their reproductive system. State health care workers find that locally based non-governmental organisations are able to draw in more of the community than the government could alone, and that they are more adept at overcoming traditional male hostility to such projects. Kulsum Abbas, a female government programme officer of the urban slums project, points out: "The women feel emancipated, and they really feel a sense of pride and enthusiasm that they are actively involved in improving the health of the whole community."

Critics, however, argue that the bank is falling short in its provision for family planning and safe childbirth, and that it doesn't adequately gauge the effect of rapid population growth on social and economic development, as seen in South Asia. An immediate step would be to increase overall lending for health by at least $1bn by the year 2000, suggests Shanti Conly, director of Washington based Population Action International: "The World Bank is the most important institution in the international development arena. The bank could help significantly reduce the toll exacted by pregnancy related illness and death, and give millions of poor couples the option of having the smaller, healthier families they want. But it needs to play a stronger role, now, in order to ensure that this happens."[7 8]

Table 1 Regional diversity in India.[4] States are listed in descending order of infant mortality

State	Infant mortality (deaths per 1000 live births)	Life expectancy at birth (years)		Unmet need for family planning (%)*	Literacy rates (%, age 7 and above)	
		Male	Female		Male	Female
Orissa	115	53.1	53.0	22.4	62	34
Madhya Pradesh	104	65.4	51.9	20.5	57	28
Uttar Pradesh	98	51.4	48.5	30.1	55	26
Rajasthan	90	53.3	53.8	19.8	55	21
Haryana	75	61.5	59.0	16.4	68	41
Karnataka	73	59.7	62.0	18.2	67	44
Bihar	73	54.2	51.5	25.1	53	23
Andhra Pradesh	71	57.2	59.8	10.4	56	34
Gujarat	67	55.5	59.3	13.1	73	49
Himachal Pradesh	67	NA	NA	NA	NA	NA
West Bengal	65	56.8	58.0	17.4	67	47
Maharashtra	59	59.6	62.1	14.1	75	51
Tamil Nadu	58	56.5	57.4	14.6	75	53
Punjab	56	62.6	63.6	13.0	64	50
Kerala	17	65.4	71.5	NA	94	87
All India	79	55.4	55.7	19.5	64	39

NA=not available.
*Percentage of couples not desiring additional children and not practising family planning.

Taxing the poor

Government officials are largely convinced that the private sector has a continuing role in the delivery of health care in India, and that user charges, although undesirable, are a necessity for the simple reason that loan monies are for a specified period, and when that time elapses, there is no other way to ensure that health initiatives are sustainable. Lack of funding has meant that the public sector offers an inadequate quality of service, forcing the poor to turn towards the private sector, which in turn exploits clients by using expensive inappropriate technologies and overprescribing.

Mr Nagarjuna, the state government project director for state health systems in Andhra Pradesh, accepts that user charges are a thorny issue: "In rural areas, patients can't even afford to have simple ailments treated privately, therefore investment in the public sector is essential. But where do we get the money from to improve facilities, and how do we sustain projects? There are other issues like finding doctors to go and work in the rural areas. The World Bank doesn't

DANIEL O'LEARY/PANOS PICTURES

Healthcare in an Indian slum

Table 2 Comparative indicators, selected South Asian countries[9]

Country	Infant mortality (deaths per 1000 live births)	GNP per capita ($US)	Literacy rate (%)	
			Male	Female
Pakistan	95	440	48	22
Bangladesh	85	230	48	24
India	76	310	64	35
Sri Lanka	15	640	93	86

address this, but we have to, and that's why we are forced to introduce user charges."

Indeed, the bank isn't as effective as it could be in other ways, and there is a delicate relationship between bank staff in Washington, those in the country, and government officials. As one bank employee explains: "The bank is a big organisation, and very bureaucratic. It's difficult to manage, and in all honesty it isn't the best managed. It isn't always clear what the objectives are and that's when development becomes difficult. It succeeds because it has good people working for it, who often have to do a lot of hard bargaining. But when things go wrong, the management in Washington blames the staff rather than the government that you're dealing with."

Despite there being a huge gap between policies and implementation, no accountability, a lack of consumer power, and a lack of community support and cohesion, India's prospects are bright because, argues Anthony Measham, "there are brilliant people in the Indian system, and the intellectual discourse is very high."

Pakistan: a loaded gun

The bank seems less confident about its approach to the health sector in Pakistan than it does in Bangladesh or India. Perplexingly, though Pakistan has the highest gross national product per capita in South Asia, other than Sri Lanka, it falls far behind the averages for health indicators for low income countries, such as infant mortality, mortality in children under 5, maternal mortality, and malnutrition (table 2). Forty per cent of the disease burden is communicable diseases: diarrhoeal diseases, acute respiratory infections, tuberculosis, and preventable childhood diseases. A further 12% is attributed to reproductive health problems. The health system is likely to come under more pressure—Pakistan's high fertility rate of 5.4 births per woman means that the population is likely to double to around 260 million people over the next two decades.

The bank accepts that it has a long way to go: "The health of the population in Pakistan has improved in the past three decades, but the pace of improvement has not been satisfactory …. Poor health status is in part explained by poverty, low levels of education (especially for women), the low status of women in large segments of society, and inadequate sanitation and potable water facilities. But it is also related to serious deficiencies in health services, both public and private."[10]

Pakistan's health system is crippled by chronic underinvestment, both in facilities and staff. Although Pakistan produces doctors at an alarmingly high and unregulated rate, most look towards the lucrative private sector; finding health professionals, especially women, to work in rural areas is difficult. The inadequacies of the public sector service mean that the private sector is heavily used—some surveys suggest it is used by 80% of the population, even by the very poor, who are barely able to afford the fees. None the less, the sheer size of the population and the extent of need ensure that public facilities remain overcrowded.

Governance of the health sector, and in general, is adversely affected by frequent changes in government, with each prime minister appointing their own staff, from cleaners to ministers. Corruption, feudalism, and high illiteracy are other factors in Pakistan's inability to develop a more effective and efficient health system.

Social action programmes

The bank's approach was to support the implementation of a social action programme starting in 1994. Richard Skolnik explains why: "In Pakistan it was the attitude of the bank that governance issues, institutional issues, and financial issues were so severe that if they weren't addressed effectively then everything else was a waste of money. Helping Pakistan to address those effectively was a sine qua non for doing anything else. And with that in mind we began to help Pakistan finance this social action programme."

Hugo Diaz, one of the bank's senior economists for South Asia, explains how a social action plan works: "They commit themselves to carrying out certain reforms, institutional reforms and policy reforms. These are mutually agreed with the donors, and they have to implement them; that is a condition for this assistance. We go there three times a year and we sit round the table to discuss progress, and if it is good then we continue assistance. If they have not made enough progress then we can stop it."

CAROLINE PENN/PANOS PICTURES

Slum life in Pakistan

But, he admits, there are drawbacks: "It's a very different sort of programme to the regular investment programme. Even now after five years of this programme being in place few people understand what it is supposed to do. This programme alone cannot do all the things that are needed. It has to be complemented by regular projects which can support more detailed work of institution building and technical upgrading of services."

Critics argue that social action programmes are ineffective and add unnecessary constraints on governments, another example of the bank's desire to impose policies that may not be appropriate for a particular country. The first social action programme was targeted at improving basic education, primary health, population welfare, and rural water supply and sanitation. By the bank's own admission, the first social action programme had limited success: it managed to raise awareness of Pakistan's poor health indicators, and encouraged greater spending on public health and preventative services, but was unsuccessful in increasing the proportion of gross domestic product spent on the health sector.[11]

The government of Pakistan produced a national health policy in 1997, and a second social action programme was finalised in 1998, with broadly similar aims.[12] Key features are decentralisation, community involvement in running government health facilities, better coordination between government and non-governmental organisations, more female health workers, and broadening the use of health insurance, along with more specific projects for communicable diseases, reproductive health, child health, nutrition, and health education. The programme, according to latest estimates, amounts to $10 bn, with $2bn provided by the bank and other donors and the rest funded by federal and provincial governments.[11]

Painful adjustment

The bank has had a tortuous relationship with Pakistan, especially over structural adjustment. Amid what the bank describes as a "slowdown in its programme of macroeconomic stabilisation and structural reforms," the Pakistan government decided in the mid-1990s to "slow the pace of key trade and tax reforms." The bank and International Monetary Fund were unhappy, and the structural adjustment loan facility that had been extended to Pakistan was cancelled, resulting in a deepening of the economic crisis.

According to the bank, "the government's timely response," ensured that a stabilisation package was negotiated with the International Monetary Fund, with the government of Pakistan finally agreeing to economic reforms. Last year's nuclear tests by Pakistan incurred economic sanctions from the international community, and, as Pakistan is more dependent on foreign aid than its nuclear competitor India, the Pakistani economy was on the verge of collapse until a last minute rescue package was arranged with the International Monetary Fund. It is easy to see why the bank and Pakistani officials are wary of each other, whereas the bank has a much more harmonious relationship with Bangladeshi and Indian officialdom.

Some Pakistani officials are also sceptical about the bank's espousal of the sector-wide approach. As one official from the health department in Punjab state told me: "With the sector-wide approach there is a problem of leadership among the donors. It may be a good idea but it is difficult for us to implement, because up to now we have focused on vertical projects, and as a result we are not geared up for it. It's all well and good for the bank to make these recommendations, which are difficult for us to oppose, but it's not easy to convince poverty stricken people that improvements at a higher level will trickle down to them, and that they have to be patient."

The people who are most affected, however, are those in rural areas. Health workers are underpaid and under-equipped, and patients are desperate for basic medical care. As one disgruntled rural hospital doctor put it: "Our secretaries [of state] write down policies in air conditioned five star hotels. They have no idea about the problems in the field."

Conclusion

South Asia exemplifies the difficulty in making the bank's prescription for the health sector work. Poverty, corruption, inadequate health infrastructure, and gender imbalance are deep rooted ills that will take many years of substantial reform to cure—and this barrier blunts the impact of the bank's policies, however much it strives to sharpen its focus.

Bangladesh is an example of the bank working in harmony with a government that is reliant on aid and is moving health indicators in the right direction. India is far less dependent on foreign funding, but its relationship with the bank remains cordial and India is the bank's largest borrower. As such, does the extent of the burden of disease and the diversity in India explain why more progress has not been made there? Pakistan, by contrast, is dependent on aid and has a less rosy relationship with the bank. It is too early to tell if social action programmes are effective in controlling its health indicators as the population grows alarmingly.

While most bank staff and government workers are upbeat about progress in the region, some government officials, and certainly many doctors, remain sceptical about the prospects of a tangible improvement in health care.

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